Appendix 13
Helpful Hints for Working With Wisconsin Medicaid

The following tips are a compilation of information collected from providers participating in the Wisconsin Occupational Therapy Association (WOTA) Medicaid Committee and information presented at symposiums sponsored by the committee. The information has been edited and updated by the Bureau of Health Care Financing therapy consultants. These tips are meant as guidelines to improve your documentation and to assist you in completing Medicaid forms accurately and completely.

Prior Authorizations (PAs)

- If information regarding the recipient's previous therapy history is unavailable, submit a PA request.
- Fill out all forms completely and accurately. Each time a PA request is sent back to the provider for more information, there is a delay in services.
- A PA request should be sent to the fiscal agent at least two weeks, but no more than three weeks, before the expiration date of the existing prior authorization.
- Check the recipient's 10-digit identification number before mailing the request to the fiscal agent.
- Please list onset dates for all diagnoses. If specific dates are not available, enter an approximate date based on the best information available and explain the circumstances.
- Count weeks and sessions accurately to ensure authorizations for sufficient sessions. Count from the requested start date. Remember, the consultant cannot grant more than you request. Please indicate if the recipient has been put "on hold" until the PA is finalized.
- The initial request for PA can be backdated two weeks to the date the request is initially received by the fiscal agent. Continuous therapy may not be backdated. To request backdating, write "Please backdate to (*date)* because (*reason*)" on the prior authorization request form (PA/RF).
- In the event that your initial PA request is returned for clarification, provide written clarification and attach your response to the original PA/RF and return this PA/RF with all attachments to the fiscal agent. The original PA/RF was stamped with the internal control number (ICN) date when it was first received by the fiscal agent. The PA may be backdated to the ICN date only if you specifically request this.
- In cases when you have difficulty getting a doctor's signature on the initial plan of care which has caused your PA to be late, attach a memo of explanation which the fiscal agent may consider in dating your authorization.
- The codes at the bottom of the PA/RF near the consultant's signature are common messages regarding action or recommendations by the consultant which have been assigned a computer code.
- Remember to use black ink. This makes the photocopies easier to read.
- A plan of care must be formulated from a valid data base (evaluation). PAs are not approved if the evaluation results are not included.
- If there is an interruption in services and you have excess sessions to use, you may change frequency if appropriate for the recipient, as long as you don't exceed the number of sessions granted or the end date. Include an explanation of the circumstances on your next PA. An amendment cannot be granted in this case.

Hints (continued)

- You may change your treatment plan during a PA; however, be sure to include the dates and rationale on your next PA request.
- Please write legibly and ensure legibility of copies. If the consultant cannot read your documents, they may get sent back.
- Only use basic or common abbreviations.
- If your PA is returned "denied," you have the right to call the consultant to discuss the decision. If the consultant agrees to change the decision, submit a new PA request with the additional documentation required by consultant. Attach a copy of the denied PA.
- If the consultant stands by the denial, the recipient has the right to appeal through the fair hearing process.
- PAs returned to the provider for more information must be returned to the fiscal agent within a two-week period.
- If the reviewing consultant writes "D/C at end of PA" on the returned PA/RF, and you feel the recipient would benefit from further treatment, write another prior authorization clarifying medical reason for additional treatment.
- Make sure your goals are objective, measurable, and functional.
- Record all progress, no matter how small.
- Include function and safety issues when appropriate.
- Use standardized evaluations whenever possible. Attach the complete evaluation to the PA request. Summarized evaluations usually do not include the full information required by the reviewing consultant to determine medical necessity.
- Include norms with test scores.
- Include specific carryover recommendations for patient, facility, staff, and/or family. After six months, carryover must be demonstrated to grant continued treatment.
- Highlight pertinent data.
- Suggested formats:
  - List your data in columns - past and present.
  - Use areas, problems resolved, problems improved, problems unresolved, carryover.
- Maintenance is a covered treatment, as long as *skilled* therapy services are required.
- "Medical Necessity" is defined in HFS 101.03 (96m), Wis. Admin. Code.

Hints (continued)

Spells of Illness (SOIs)

- New diagnoses or exacerbations that result in a functional regression generally qualify as a spell of illness.
- Be sure to include a copy of the current evaluation, a comparison to prior abilities, and an estimate of the patient's ability to return to prior level of function.
- Remember, any health insurance, including Medicare-paid sessions (excluding inpatient hospital days) *count* toward the original 35 days of treatment for a spell of illness.
- You may submit a copy of the monthly signed doctor's orders in lieu of a signature on the Prior Authorization Therapy Attachment (PA/TA), as long as the order indicates what treatment the doctor is prescribing.

General Information

- BID treatment counts as one session, so long as it does not exceed 90 minutes per day.
- Daily treatment time should not exceed the limitation of 90 minutes, per treatment day. However, under extraordinary circumstances you may request more time. After you receive payment for the 90 minutes, submit an adjustment form with the specific reason for exceeding the 90 minute limitation documented on the adjustment form.
- Make sure treatment and documentation are in accordance with the Wisconsin Administrative Code laws and practice standards.
- Splinting treatment, including evaluation and associated expenses, is billed separately from other treatment sessions as durable medical equipment. Refer to the Durable Medical Equipment (DME) Index for correct procedure codes.